University of Toledo Ambulatory and Outpatient Services Guideline

Title: Suicide Risk Screen and Care

Purpose: This guideline outlines the procedures and documentation for Suicide Screening of UTMC clinic patients ages 12 years and older.

Ambulatory Clinics: Use the 9 question Patient Health Questionnaire (PHQ-9)

Recurring Appointment Clinics: Use the Columbia Suicide Severity Rating Scale

Related Policies: 3364-101-02-01 Ambulatory Medical Record, 3364-100-45-18 Assessment and Reassessment

Accountability: The staff member performing the intake process when the patient arrives for their appointment or procedure is responsible for completing the appropriate suicide screening tool. A staff member is responsible to monitor patient safety. The treating provider is to implement a plan of treatment based on his or her clinical judgment.

This guideline is applicable to all ambulatory clinics including Dana Cancer Center, Endoscopy, Anti-Coagulation Clinic, Interventional Pain, Basic Outpatient Procedure (Infusion,) and Outpatient Rehabilitation not already covered by a clinic specific suicide guideline or policy

Frequency: The suicide screening tool is to be completed at each clinic visit.

In the reoccurring visit areas, Outpatient Rehab, Outpatient Infusion and Anti-Coagulation, the suicide screen is to be completed on the first patient encounter and as needed based on change in condition or emotional state.

Procedure:

Clinic with Physician Present

1. During the intake process the staff member is to complete all questions of the PHQ-9.
2. If the patient responds, “Not at all” to question #9, “Thoughts that you would be better off dead or of hurting yourself,” no further action is needed.

3. If the answer to question #9, "Thoughts that you would be better off dead or of hurting yourself," is any answer other than "Not at all", the screening is considered positive. The following actions should be completed.

   Staff

   a. Implement patient safety monitoring.
   b. Notify the provider immediately.
   c. Complete the "Steps to Chart Once" section of the suicide precautions charting.
   d. Complete the "Check Every 15 Minutes" section of the suicide precaution charting every 15 minutes until the provider notifies the clinic staff the patient is safe to return home or until the patient is transferred to the Emergency Room or another acute care mental health setting.
   e. Two staff members will escort the patient to the Emergency Department if the provider orders an emergent psychiatric evaluation.

   Provider

   a. Assess the patient including the PHQ-9 responses.
   b. Dependent on the provider's assessment, the provider may order medication, refer to outpatient mental health treatment, refer to social work for resources or emergency services as determined by the evaluation.
   c. Document any suicidal ideation, observed behaviors, assessment, and plan in the EHR.
   d. Notify the staff and document in the EHR that the patient is safe to return home, if appropriate, as determined by the evaluation.

Other Clinic Types

1. The staff member performing the intake process will complete the Columbia Suicide Severity Rating Scale during the first patient encounter and as needed based on changes in the patient's condition or emotional state.
2. The staff member will complete all questions on the Columbia Suicide Severity Rating Scale. Based on patient responses, the staff member will implement the appropriate response and disposition plan according to the final risk score.
   a. Low Risk: Contact Social Worker for Community Resources and/or referral to treatment.
   b. Moderate Risk: Consult provider, psychiatry resident on-call, and/or Social Worker.
   c. High Risk: Implement patient safety monitor/procedures, complete the Outpatient Clinic Suicide Precautions Checklist, consult provider, psychiatry resident on-call, and/or Social Worker.

All Clinics

1. Patient Safety Monitoring
   a. Do not leave the patient by themselves.
   b. Clear all items from the room that could be used by the patient for self-harm.
   c. Place the patient on continuous observation.
   d. If the patient refuses to stay in the clinic, staff member will contact UT Security to assist.
2. Before leaving the clinic, a staff member will provide the patient and or their family The Depression Treatment Patient Care form, which contains the number for the National Suicide Prevention Lifeline.
3. Follow Up Care
   a. Provider is to request, if applicable, the clinic staff contact the patient for follow up care or to verify patient follow through with referrals or treatment plan.
4. Telehealth Considerations
   a. When performing a telehealth appointment with a patient, the staff member should confirm:
      - The patient's physical location.
      - A telephone number to contact should they lose connection.
      - An emergency contact and their phone number should the staff member need to contact to assist in maintaining patient safety (e.g., while waiting for emergency services/911 to arrive).
   b. If a patient expresses a psychiatric emergency during a telehealth appointment:
      - The staff member is to attempt to remain on the phone with the patient.
      - The staff member is to contact 911/emergency services to request a well check.

References:

The Joint Commission (2019). National patient safety goal for suicide prevention. R3 Report: Requirement, Rationale, Reference. Retrieved from https://www.jointcommission.org/-/media/tjc/documents/standards/r3reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf

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